DOCUMENT RESUME

ED 185 481 CG 014 379

TITLE	Quality Assurance in Mental Health Centers.
INSTITUTION	Southern Regional Education Board, Atlanta, Ga.
SPONS AGENCY	National Inst. of Mental Health (DHEW), Rockville, Md. Div. of Manpower and Training Programs.
PUB DATE	79
GRANT	1-T15-MH14703
NOTE	30p.; For related documents see CG 014 377-378 and CG 014 380-381.
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Accountability; Community Services; Federal Regulation; *Mental Health Clinics; *Peer Evaluation; *Program Effectiveness; Program Evaluation; *Quality Control; *Standards; State of the Art Reviews

ABSTRACT

Federal legislation requires mental health centers to establish quality assurance programs which seek to maintain or improve the quality of a center's health care services. Three general measures of quality are: (1) input standards for staff and the setting providing care; (2) process standards for the quality of treatment; and (3) outcome standards for the results of care. Federal guidelines recommend that mental health centers model their quality assurance programs after the Professional Standards Review Organization's (PSRO) assessment method. However, PSRO activities evaluate physical health care, and they focus primarily on input measures of quality. Contrarily, quality assurance programs in mental health centers focus on the treatment process. Clinical peer review is the major monitoring tool, and only clinical personnel may conduct peer reviews and make quality assurance decisions. Although every mental health center's standards should reflect normative mental health standards, each center's standards should be flexible, meet local needs and be self-imposed. (Author/MLT)

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ED185481

QUALITY ASSURANCE IN MENTAL HEALTH CENTERS

Southern Regional Education Board
130 Sixth Street, N. W.
Atlanta, Georgia 30313

1979

CG 014379

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FOREWORD

The Southern Regional Education Board was awarded a grant (Mental Health Training Grant No. 1-T15-MH14703) in late 1976 from the State Manpower and Development Branch of the National Institute of Mental Health. The Project was to develop publications and conduct workshops to assist mental health centers in improving their management practices and their program activities through the use of practical program evaluation. A series of publications and workshops is being developed through the combined efforts of the Board's staff and task force participants. Topic areas include:

- The Administrative Uses of Program Evaluation
- Use of Information Systems for Monitoring Mental Health Programs
- Linking Needs Assessment to Program Planning and Management
- Quality Assurance in Mental Health Centers
- Client Outcome Evaluation in Mental Health Centers
- Improving Staff Productivity in Mental Health Centers

The selection of these topics was based on the preferences expressed in a survey of mental health centers and clinics in the 14 states served by the Southern Regional Education Board.

Quality Assurance in Mental Health Centers explores the origins of current quality assurance efforts in mental health, and makes some suggestions for the organization and operation of quality assurance programs. This publication is based on the recommendations of people in mental health centers and state mental health agencies. We thank all of them for their willingness to share their knowledge and experiences with us. We assume responsibility for the content of this report, including any misunderstandings resulting from the translation of ideas.

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WHAT IS QUALITY ASSURANCE?

The requirements of the Community Mental Health Centers (CMHC) Amendments of 1975 (PL 94-63) and the mental health program standards for accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH) have created a new interest and emphasis on quality assurance activities within mental health centers. The CMHC amendments require (1) that national CMHC standards be developed, (2) that states develop standards for mental health facilities and programs, and (3) that federally funded centers establish quality assurance programs. In addition, the JCAH standards for mental health programs include case audit requirements that are similar to those set for quality assurance programs in federally funded centers.

The purpose of this publication is to explore the origins of current efforts to assure the quality of mental health care; to examine some of the conceptual and technical issues encountered by mental health centers in adapting quality assurance procedures to outpatient services; and to make some suggestions for the organization and operation of quality assurance programs based on the actual experiences of several community mental health centers.

Towery and Windle define quality assurance as:

> . . . an activity or set of activities aimed at or resulting in maintaining or improving the quality of health care services.[1]

The requirements of the various agencies differ in the extent of activities and kinds of clients whose care must be reviewed, but all see quality assurance as a process designed (1) to review the quality and appropriateness of services provided to clients, and (2) to assist in making decisions about improving or correcting deficiencies in individual client care and in overall clinical procedures. All emphasize peer review as necessary and desirable on the assumption that caregivers are best qualified to make decisions about professional standards of care. The actual review process calls for the identification and correction of deficiences in care through comparing the actual services provided against criteria which specify the appropriate treatments for clinical problems or illnesses. Clinical care that does not conform to these criteria is referred to a committee of peers for review and corrective actions.

HISTORICAL BACKGROUND

The assessment of the quality of health and mental health care is not new. Three general aspects of quality assurance have evolved over the past hundred years or more. The first relates to the quality of the staff (i.e., educational requirements and credentials of physicians and other practitioners), and standards for the setting in which care is provided. This aspect focuses on the inputs to the treatment. The second aspect is the quality of the treatment processes. The third aspect involves the assessment of the results of care or outcomes. No single approach has been determined to be adequate in itself. All three are used to some extent in the assessment of the quality of health and mental health care.

The early roots of quality assessment in mental health trace back to the early 1800s when Pliny Carl, Rufus Wyman, and Thomas Lee attempted to create standards of ethical practice and professional competence for the care of the mentally ill in asylums in New York, Philadelphia, and Boston.

However, most current quality assessment methods have been developed by the field of physical health and adapted to mental health settings.[2]

In the late 1800s the assessment of the quality of medical care began with attempts by the Illinois State Board of Health to establish professional competencies for the licensure of physicians. Shortly after the turn of the century, the American Medical Association and the Carnegie Foundation for the Advancement of Teaching jointly sponsored a survey of medical schools. This study, conducted by Abraham Flexner, resulted in recommendations for a standardized curriculum for "scientific" medical education and established the principle of full-time faculty holding joint appointments in teaching hospitals. Following the completion of the Flexner Study, E. A. Codman developed a method for auditing the outcomes of surgery and identifying the reasons for good or poor results. Codman proposed to the American College of Surgeons that all hospital surgery be subject to medical outcome audit. The College decided, largely because of the findings of the Flexner Study, that physicians and hospitals would be best served if a program was established to bring performance up to acceptable levels through improving medical education and setting minimal standards for hospitals.

The initial approach to improving the quality of medical care resulted in programs of accreditation for hospitals based on input standards for hospital administration (i.e., qualifications of staff, and specific facility

and equipment requirements). The American College of Surgeons transferred responsibility for the accreditation of hospitals to the Joint Commission on the Accreditation of Hospitals (JCAH) in 1952.

By 1928, the conceptual foundations of quality assessment had been developed. Structural (input) approaches were being used; standards for outcomes were not used on a national basis until much later, perhaps because the influence and acceptance of structural improvements in hospitals made the need to assess outcomes appear unnecessary.

In the next four years, the Committee on the Costs of Medical Care laid an analytical foundation for the development of the process approach to quality assessment. The analytical methods used in a series of studies by the Committee were based on two major factors. The first was the desire to understand and control the rapidly rising costs of health care. The second was the professional interest in the quality of health care and the way to assess it. Numerous studies based on the Committee's work began during the late 1940s and continue to the present. The basic issues of the cost and quality of health care were first introduced in 1928, and subsequent studies have had a strong influence on legislation, beginning with a nationwide health care review program enacted in 1972.

This program (Title XI of the Social Security Act) establishes Professional Standards Review Organizations (PSROs) at state and local levels to review institutional care (hospitals and long-term care facilities) for which payment is made under Medicare, Medicaid and Maternal and Child Health

programs (and presumably any recipients of any future national health care insurance). Its stated purpose is to provide efficient, effective, and economical health care of proper quality.

PSROs function as peer review groups performing three types of process assessments: (1) concurrent reviews to ascertain the medical necessity of a patient's admission and continued stay in a hospital; (2) evaluation studies of the quality of care provided to groups of patients; and (3) profile analysis of aggregated data on clients or practitioners.

PSROs establish their own review criteria based on national guidelines (model screening criteria) developed by specialty groups including mental health. Deficiencies identified by review and evaluation may lead to recommendations by the PSRO that will upgrade services. The responsibility for evaluating the quality of care provided to groups of patients can be delegated by the PSRO to facilities, such as community mental health centers, with acceptable quality assurance programs.

Unlike the beginnings of the assessment of the quality of physical health care which focused on the input aspects, the earliest efforts at assessing the quality of mental health care began with the process aspects. One of the earliest forms was the joint staffing of cases in which the responsible clinician presented diagnostic findings and proposed treatment plans to a group of clinical peers. This type of peer review was the foundation for mental health quality assurance programs.

The development of nationwide quality assessment mechanisms in mental health has been primarily a collaborative effort between the JCAH and the National Institute of Mental Health (NIMH) that has been prompted by the

requirements of federal health care reimbursement programs (primarily Medicare and Medicaid). These programs give automatic federal certification for reimbursement to facilities and programs that are accredited by the JCAH. Unlike the PSRO program, JCAH quality assurance requirements apply to all patients, not just recipients of federal reimbursement programs.

JCAH accreditation standards for psychiatric hospitals were developed in response to a change in Medicare "conditions of participation" (standards) made in 1966. This change was designed to preclude payment for mental patients receiving only custodial care. Two specific conditions that have influenced the development of quality assurance programs in mental health centers were: (1) the requirement for "active treatment" that is expected to improve the condition of patients; and (2) the requirement that medical records be maintained to permit a determination of the intensity of treatment provided for each Medicare recipient.

Until the enactment of the Community Mental Health Centers Act Amendments (PL 94-63) in 1975, quality assessment activities were voluntary and mainly applied to mental health center inpatient services. Centers that contracted for inpatient services from psychiatric or general hospitals were not affected. The amendments to the Community Mental Health Centers Act placed new requirements for quality assessment on mental health centers.

The intent of the Community Mental Health Centers Act Amendment is often described by the term "accountability." It incorporates the three traditional aspects of quality assessment.

Input or structural standards. Standards designed to assure that the facility and its staffing meet basic quality requirements. Standards apply to personnel, facilities, equipment, information and record systems, organizational structure, and financing. However, compliance to these requirements does not equate to quality care. The assumptions behind these standards are that: (1) it is possible to identify what is "quality" in terms of staffing, physical structure, and formal organization; and (2) better care is more likely when qualified staff, adequate facilities, and sound fiscal and administrative procedures are in place.

Process standards. Standards and criteria designed to assess the processes and procedures for providing care. These standards relate to the activities of mental health programs in the treatment and management of patients. The assumption behind process standards is that the persons responsible for delivering mental health services can agree on what constitutes quality treatment without regard to outcome. The appraisal of process provides feedback to assure that clinical activities are carried out as they should be.

Process standards are professionally developed criteria for clinical procedures for specific types of clients. Actual practice is compared against these criteria through utilization and peer reviews. There are two types of explicit process standards: normative standards derived from the opinions of recognized leaders in the mental health professions (e.g., NIMH and professional associations) and empirical standards based on the patterns of care found in actual practice in specific localities. Both are derived from

observations and experimentation and, therefore, are subject to continual change. Many centers choose to develop their own outpatient standards because existing standards are designed primarily for use in hospital settings.

While mental health centers are required to use explicit standards, in actual practice, implicit criteria based on the professional judgments of peers on individual cases often form a basis for decisions about the appropriateness of treatment services in peer review.

Outcome standards. These standards are designed to assess the results of treatment. Criteria for outcome standards measure recovery or restoration and relate to the result of treatment in terms of each client's mental health status. The assumptions behind this approach are that : (1) professional and social views are in accord on what constitutes desirable results; and (2) good results can be translated into measures that reflect the effectiveness of the care-giving process.

To date, standards for treatment outcomes for mental health center clients have not been developed and, therefore, are not required. Several factors make using outcome standards for client care difficult: (1) the selection of appropriate measures for all groups of clients is controversial, and (2) the relationship between clinical processes and treatment outcomes is hazy because of influences outside the control of clinicians.

FUTURE TRENDS

The proposed Mental Health Systems Act requires that standards be developed and used to negotiate performance contracts and monitor the progress

of state and local mental health programs. It is most probable that requirements for quality and cost-containment will be included in the proposed performance-contracting and monitoring processes.

THE ORGANIZATION AND OPERATION OF QUALITY ASSURANCE PROGRAMS

Quality assurance activities in mental health centers are based largely on the process aspects of quality assessment. Quality assurance activities are intended to improve the quality of care by monitoring the clinical care of individual clients and groups of clients by clinical peers.

However, there are also input aspects to quality assessment of mental health centers. These are intended to improve the quality of care through adequate standards for fiscal and overall program management, qualified staff, and adequate facilities and equipment. Reviews for compliance to structural standards are usually conducted by outside agencies (e.g., federal and state mental health agencies, JCAH).

Federal guidelines describe the basic attributes of a quality assurance program in a federally-funded mental health center. These basic attributes are:

1. A quality assurance committee must be established to be responsible for directing the quality assurance program. The composition of this committee must be multidisciplinary with representation from all relevant disciplines and service units. This committee may develop its own review procedures but evaluation studies similar to those required by PSROs should be included.

2. The committee will develop standards and criteria for the review process.

3. The committee will write a plan describing the quality assurance program and make it available to center staff, patients, governing bodies, and the public.

4. The findings of the review process are to be disseminated to center staff and its board and to "other appropriate bodies and persons."

Although specific rules and regulations for review procedures and standards have not been established by NIMH, the guidelines recommend that quality assurance activities should be similar to those defined by PSROs. These are:

1. Admissions Certification -- a review to assure that each admission to the inpatient service is necessary.

2. Continued Stay Review -- a review to assure that patients' stay in inpatient services is no longer than necessary.

3. Clinical Care Evaluation Studies or Audits -- studies which document the extent to which care provided is in accordance with pre-established quality of care criteria.

4. Profile Monitoring -- the analysis of aggregate data regarding patterns of care for selected kinds of patients or staff.

PSRO quality assurance activities generally focus on physical health care and the clinical work of physicians. To organize a quality assurance program in a mental health center, these activities require modification to include other aspects of care and the work of other professionals in addition to physicians.

THE ORGANIZATION OF A QUALITY ASSURANCE COMMITTEE

Mental health has commonly used team approaches in the care of patients. Joint staffing conferences and the review of individual clinician's cases by supervisors have been the primary mechanisms to monitor the quality of clinical management. Multidisciplinary peers include psychiatrists, psychologists, nurses, social workers, and other therapists.

By NIMH direction, quality assurance committees should be staffed so that (1) all service units are represented, and (2) all clinical disciplines

are represented as voting members in the review process. It is suggested that centers include other staff as ex-officio members to provide support services (e.g., the evaluator, the clinical records administrator, and the coordinator of staff development). These persons can provide technical assistance and information that helps link clinical issues to the overall operations of the center.

Only clinical care providers should vote in peer reviews and make recommendations for corrective action. Non-clinical staff, such as medical records technicians, may draw sample cases for review, screen cases for specific characteristics, or identify technical deficiencies in record-keeping if guidelines are provided by the quality assurance committee.

The tenure of office of quality assurance committee members may vary. In some centers, staff are appointed or elected for two-year staggered terms, while in other settings members may serve only one-year terms. The important issues are that: (1) there are several staff members who are experienced in the review process at all times, and (2) the review process also serves as a kind of staff development. All staff members should have an opportunity to serve on the committee at some time.

THE OPERATION OF A QUALITY ASSURANCE PROGRAM: HOW IS IT DONE?

Documentation is available for inpatient quality assurance procedures in Hagedorn, et al, A Working Manual of Simple Program Evaluation Techniques for Community Mental Health Centers, DHEW Publication (ADM) 76-404, 1976.

In mental health centers, quality assurance programs for outpatient services usually include the following procedures:

- o Case Identification -- monitoring records for apparent deviation from the procedures established by the center, including technical deficiencies (e.g., incomplete records) and major deficiencies in clinical procedures.

- o Peer Review -- an in-depth review by peers (voting members of the quality assurance committee) to make judgments and recommendations on the technical aspects and appropriateness of care provided to a client.

- o Care Evaluation Studies and Profile Analysis -- studies which document the extent to which the center's overall patterns of care and treatment are in accordance with pre-established criteria and identify patterns of care provided to specific types of clients by service units and practitioners.

Case Identification

Many centers screen all client records for technical and clinical deficiencies. These deficient records are identified on the basis of pre-established criteria, such as length of time in treatment, problem type, re-admissions, and requirements set for the content of case records. In many centers, the staff time available for identification of deficient case records is limited and a case selection process is needed. The criteria for selection may vary and may include one or more of the following:

1. Random selection of cases from the agency's overall case load.
2. Random selection of each therapist's case load.
3. Selection based on third party payer requirements.
4. Other criteria, such as numbers of visits, problem types, re-admissions, etc.

The primary aim of case identification is to assess and improve the quality of care. While the identification of technical deficiencies in records is a housekeeping task that is of secondary importance, it is a necessary step to document what care actually was given to clients. Many

centers return technically deficient records to clinicians for completion. These cases are not reviewed by peers unless the clinicians are unwilling or unable to complete the records as requested.

Peer Review

Cases that are identified as deviating from standards are reviewed by members of the quality assurance committee. The general procedures are:

1. Review cases that appear questionable.
2. Make recommendations on each case -- either affirming what was done or recommending corrective action.
3. Inform the therapist and set up a conference if required.
4. Re-review case to assure that appropriate action has been taken.
5. If action has not been taken, refer case to the appropriate authority (center director, clinical supervisor).

In some centers, case identification and peer review are part of the same process. In larger centers, particularly those who have well-developed review criteria or standards, clinical records staff identify cases that deviate from criteria and refer them to the review committee.

What Happens as a Result of Peer Review? One of the results of peer review is the identiffcation of areas for informal and formal staff development. Participation in a peer review committee is an educative process for a clinician. At the same time, the individual clinician whose cases are reviewed (particularly when the problem relates to actual client care) benefits from the recommendations of the committee in learning new or better ways to deal with clients.

Some suggested kinds of staff development approaches to assist clinicians in handling cases more appropriately are (1) a group review of the case, (2) video or audio tapes of a clinician and patient and discussion of better ways to handle the patient, (3) case conferences, and (4) equipping the therapist with a listening device so that he can hear suggestions from a viewer behind a one-way mirror.

The following suggestions may assist in improving the quality of care in outpatient services:

- o A team approach to treatment often heads off the need for corrective action.
- o A follow-up should be done to make sure that the recommended actions have been taken.
- o Peer review reports should be used to identify the topics to be addressed in formal staff development programs.
- o Peer review reports should be used to assist center managers in making changes in organizational and clinical procedures that constrain clinicians in providing quality care.
- o Peer review reports may provide the basis for improvements in clinical procedures (e.g., intake procedures, centralized booking of appointments, new treatment modes, or a new system for assigning cases to individual clinicians), the allocation of staff and other resources in clinical and/or support services.

Clinical records are the primary source of case documentation of the quality of care provided to patients. When adopting the utilization review requirements of PSROs to ongoing outpatient services, many centers find it necessary to modify the format of clinical records so that content and format are complete and clear. Some state agencies are now attempting to standardize the format and content of clinical records in all publicly funded mental health centers so that the records will contain specific required information

as well as allow for additional content needed by individual agencies. Information that accounts for the psychological, physical, educational/vocational, and social aspects of clients' condition, define the goals of treatment, and the specific methods to be employed for attaining these goals are included. Progress notes are related to the treatment planned for clients. Some centers also include ratings of the functioning level of clients for each visit. This assists reviewers in assessing the results of treatment as well as the quality of care provided to clients.

It should be noted that good records do not equate to good care, but they document it.

Clinical Care Evaluation and Profile Analysis

There are varying definitions of clinical care evaluation studies in mental health centers. In the broadest interpretation, these studies may range from studies of client satisfaction to studies of the utilization patterns of specific client groups (e.g., previously hospitalized patients). Narrower interpretations, such as those of PSROs, deal with comparisons of actual care provided to established clinical criteria. A list of characteristics of both care evaluations and profile analysis in mental health centers is given below.

1. Studies should be based on aggregate data of identifiable groups of clients.

2. Usually data are analyzed retrospectively -- not while clients are receiving care.

3. The selection of studies may be initiated by different people -- the center director or clinical services director, the evaluator, a clinician, the quality assurance committee.

Regardless of who initiates a request for a study, the quality assurance committee should approve those studies that explore issues related to the quality of care provided to clients.

4. Studies should be conducted in areas where a commitment to act on findings exists. Otherwise, the cost in staff time and other resources is difficult to justify.

Initially, many areas of clinical care can be studied on an exploratory level through the use of program evaluation techniques instead of undertaking an in-depth research study of client care. If a problem is identified, the decision can then be made to proceed with an in-depth study requiring more time-consuming data collection. Where most program evaluation methods use data from the center's statistical information system, in-depth care evaluations require abstracting data from clinical records and/or collecting new data. The major concerns are the greater costs and degree of detail required for care evaluation studies.

Clinical care evaluations should not be conducted in areas where there is no perceived problem, or little potential for improvement because of known constraints.

CRITERIA AND STANDARDS

There is some controversy over the kinds of standards to use in CMHC quality assurance. The issue is whether the use of normative national standards (e.g., those derived from the opinions of leaders in the mental health profession) is more appropriate than the use of empirical standards based on the patterns of care found in actual practice within a specific center.

It is argued that normative standards tend to dictate the provision of care in local programs and that they contradict the intent of the CMHC Act which encourages the tailoring of mental health services to the needs of local communities.

The other position argues that mental health care will be highly variable when reviewed on a center-by-center basis. In either case the implicit criteria employed by peer reviewers may come closer to the actual clinical decision-making process than any explicit criteria.

The purpose of setting explicit standards for quality assurance programs should be to meet local needs. Standards serve as a basis for judgments about the quality of care, but they also may be used in liability issues. Quality assurance committee members tend to use existing normative standards as a general reference source or a starting point for the development of explicit local standards.

A standard is seen as a unit of measure that serves as a screening device to identify and assess acceptable and unacceptable performance in clinical care. Some suggestions for the use of standards are shown below.

- Standards should allow flexibility in describing the range of acceptable performance. They should be dynamic so that they adjust to changing circumstances. They should be self-imposed, not externally imposed.
- PSRO has recommended standards for inpatient care, but to date there are no generally accepted standards for outpatient and other types of services provided by mental health centers.
- Different standards should be developed for client groups and for stages of the treatment process, such as admission/intake, acute treatment, and continued stay procedures.

One of the major difficulties in setting standards for quality assurance programs lies in achieving agreement on what the standards should be. There are several suggestions for developing standards:

- Develop simple, minimal standards and refine them over time. These initial standards do not have to be comprehensive and should have an "elastic clause" to cover specific situations.
- Develop standards as a response to frequently recurring problems in clinical practice.
- Use professional ethics and standards of practice as a broad base for judgments.
- Use the Bill of Rights for Patients, and externally imposed standards (state, JCAH) as a basis for the development of standards.
- Start with known clinical practices within a center and develop explicit, center-specific criteria and standards over time. Build in flexibility through periodic review using current practice and norms within the center as well as those drawn from outside sources.

Some examples of minimal standards are:

- The content of clinical records and the documentation of client care must comply with specific requirements;
- Medication review must be done at specified intervals;
- Assessment and treatment planning for clients must be done within a specified time period;
- When only one contact is necessary, or desired by a client, a clinical case record will not be opened;
- A therapist must document with the quality assurance committee the need to carry an outpatient case beyond a period of six weeks;
- All cases will be reviewed after 90 days to identify inactive cases;
- The cases of all medicare/medicaid beneficiaries will be reviewed after every 90 days of continuous treatment.

Explicit standards developed by mental health centers are used to identify cases that appear to be unacceptable. Peer review activities are designed to permit clinical peers to make judgments based on implicit criteria for good clinical care and the total pattern of the case.

THE ROLE OF EVALUATION IN QUALITY ASSURANCE PROGRAMS

The Community Mental Health Centers Amendment of 1975 also requires that federally funded centers have a program evaluation unit that (1) collects and evaluates statistics on the cost of operations, the patterns of utilization of services, the availability, accessibility and acceptability of services, and the impact of services on residents; and (2) reviews its statistical information with catchment area residents to assure that services meet their needs (citizens' review).

Quality assurance and program evaluation activities are distinct types of evaluation with some similarities in practice. Until recently the two have not been linked because the focus of their concerns are different.

- Program evaluation focuses on providing information to assist center administrators in making decisions about program effort, efficiency, effectiveness and adequacy, and in encouraging community awareness and feedback.
- Quality assurance programs focus on the review of care provided to clients to assist professional caregivers in making clinical decisions about individual clients and groups of clients. The results of quality assurance activities are used primarily by clinical staff in improving clinical care.

In most mental health centers, the program evaluator is responsible to the center administrator to develop and execute an annual evaluation plan that is congruent with, and complementary to, the center's annual plan for program and budgets, and to monitor, analyze and report program data to the center's

managers. In actual practice, program evaluators serve in many other capacities, particularly in small organizations. The evaluator is often an ex-officio (non-voting) member of the quality assurance committee who shares facts about the operation of the program and specific service modalities that are relevant to the clinical quality of care. Often the program evaluator shares responsibility for the development of the quality assurance program.

Some of the specific activities in which the program evaluator and the quality assurance committee overlap and complement each other are:

1. The program evaluator may identify the need for clinical care evaluations.

2. The program evaluator can assist in the design of clinical care evaluations.

3. Clinical care evaluations can provide in-depth answers to questions raised in the analysis of program evaluation data.

4. The combination of clinical care evaluation and program evaluation provides information about problems from two perspectives: quality issues and programmatic issues. This linkage is often important in making policy decisions.

5. Quality assurance committees often use program evaluation data to assist in developing standards for utilization review.

SUMMARY

Quality assurance is an activity or set of activities aimed at or resulting in maintaining or improving the quality of health care services. Most current quality assessment methods have been developed by the field of physical health and adapted to mental health settings. Three general measures of quality have evolved: (1) input standards for the staff and setting in which care is provided; (2) process standards for the quality of treatment; and (3) outcome standards for the results of care.

Quality assurance programs in mental health centers are primarily concerned with maintaining or improving the quality of the treatment process through the monitoring of the clinical care of clients by clinical peers. Federal guidelines describe the basic organization and activities of a quality assurance program in a mental health center and recommend that activities should be similar to those defined by Professional Standards Review Organizations (PSROs). Because PSRO activities focus on physical health care, they must be modified for use in mental health centers. Non-clinical personnel can be included in the quality assurance committee as ex-officio members to assist in linking clinical issues to overall operations and carrying out recommendations for improvements in clinical care. However, only clinical personnel should conduct peer reviews and make recommendations for corrective action.

Quality assurance activities in outpatient services usually include case identification, peer review, and care evaluation studies.

Quality assurance standards and criteria provide a basis for judgments about the quality of care. They serve as a screening device to identify acceptable and unacceptable performance in clinical care. Normative standards developed by leaders in the mental health profession may be used as a starting point for developing standards, but mental health centers should develop explicit standards that are flexible, meet local needs, and are self-imposed.

Until the enactment of the Community Mental Health Centers Act Amendments of 1975, quality assessment activities within mental health centers were voluntary and mainly applied in inpatient services.

Quality assurance and program evaluation activities have not been linked until recently because the focus of their concerns is different. The program evaluator can assist in organizing quality assurance programs, serving as an ex-officio member of the committee who is knowledgeable about programmatic concerns and developing the design of clinical care evaluations.

Quality assurance reviews and decisions are limited to clinicians. If the recommendations of the quality assurance committee are to have an impact on the quality of care, the cooperation and assistance of administrative and support staff are needed to integrate clinical process into general programmatic concerns in a mental health center.

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Greenwood, South Carolina

Colorado Division of Mental Health
Denver, Colorado

Community Mental Health Center of Palm Beach County
West Palm Beach, Florida

Dede Wallace Center
Nashville, Tennessee

Manatee County Community Mental Health Center
Bradenton, Florida